STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		15G606	A. BUIL B. WIN			07/10/	2014
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				REENHILLS LN S		
REM-IND	IANA INC				APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000000							
		r an extended annual	W00	00000			
	recertification an	nd state licensure survey.					
	Dates of Survey: 7/7/14, 7/8/14, 7/9/14 and 7/10/14						
	Facility Number	: 001175					
	Provider Numbe						
	AIMS Number:						
	111110 1 (01110 011	1002.00.0					
	Surveyor:						
	Keith Briner, QI	DD.					
	Keitii Billici, Qi	ы					
	findings in accor	es also reflect state dance with 460 IAC 9. completed 7/17/14 by					
	Ruth Shackelford	d, QIDP.					
W000104	483.410(a)(1)					İ	
	GOVERNING BOI						
		dy must exercise general d operating direction over					
	•	review and interview for	Woo	00104	The Program Director and Hor	ne	08/09/2014
		lients (#2), the governing			Manager will be retrained on		-
	_	tercise general policy,			Client Finances, including		
	-	ating direction over the			ensuring that the client is not c	over	
	•	client #2's personal			resources at any time. All financial transactions are		
		ot in excess of the			monitored by the Home		
					Manager,reconciled on a mont	thly	
	-	naximum amount allowed			basis by the Program Director,		
	by Medicaid.				and then reviewed by the Clier	nt	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G606	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/10/2014
	PROVIDER OR SUPPLIER DIANA INC	3025 G	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Client #2's financial record was reviewed on 7/8/14 at 7:50 AM. Client #2's facility based cluster account dated 4/1/14 through 6/30/14 indicated an ending balance of \$2,344.29. Client #2's personal community based checking account ledger dated July 2014 indicated an ending balance of \$446.15. The review indicated client #2's personal finances/resources exceeded \$2,000.00. AD (Area Director) #1 was interviewed on 7/8/14 at 1:45 PM. AD #1 indicated client #2's personal finances were in excess of the \$2,000.00 Medicaid limit.		Finance Specialist at the completion of each month. Or a month the Client Finance Specialist will notify the Area Director of all clients, if any, th are over resources, so that the Area Director can follow up on plan of correction. Ongoing, th Area Director will complete quarterly reviews of a random sample of client finances to ensure that all is completely accurately and correctly. Responsible Party: Home Manager, Program Director, Client Finance Specialist, and Area Director.	at e the
W000126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on record review and interview for 2 of 3 sampled clients (#1 and #3), the facility failed to ensure clients #1 and #3 were taught to manage their financial affairs. Findings include:	W000126	The Program Director will be retrained on writing client goal and objectives based on their individual needs. The Program Director, in conjunction with th Interdisciplinary teams,will cre a money goal for clients 1 and Ongoing, the Program Directo	e ate 3.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet

Page 2 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G606	A. BUILDING B. WING	COMPLETED 07/10/2014
	PROVIDER OR SUPPLIER DIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
	1. Client #1's record was reviewed on 7/8/14 at 11:24 AM. Client #1's ISP (Individual Support Plan) dated 5/15/14 indicated client #1 did not independently manage his financial affairs. Client #1's ISP dated 5/15/14 indicated the client #1 should " increase money management skills through a formal goal." Client #1's record did not indicate documentation of a formal money management training objective or informal money management training supports to assist client #1 to become more independent in the management of his financial affairs. 2. Client #3's record was reviewed on 7/8/14 at 10:07 AM. Client #3's ISP dated 1/24/14 indicated client #3 did not independently manage his financial affairs. Client #3's ISP dated 1/24/14 indicated the recommendation to "Increase money management skills through a formal goal." Client #3's record did not indicate documentation of a formal money management training objective or informal money management training objective or informal money management training supports to assist client #3 to become more independent in the management of his financial affairs. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on	will work with the interdiscipli teams to ensure that each cli has training goal to identify the specific areas of need. Ongo all Individualized Support Plate will be reviewed by the Area Director and/or Quality Assur Manager, to ensure accuracy to ensure that all areas of neare met for each client. Responsible Party: Program Director, Area Director, and Quality Assurance Manager.	ent neir ing, ns ance v and
	7/8/14 at 1:30 PM. QIDP #1 indicated		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE		ETED		
		15G606	B. WIN			07/10/	2014
	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	clients #1 and #3 management trai	did not have money ning objectives.					
	9-3-2(a)						
W000149	written policies an mistreatment, neg Based on record 1 of 5 allegations mistreatment, ex unknown origin failed to implem procedures to en investigation of a clients #1, #2, #3 reported to the adbusiness days of Findings include The facility's BE Developmental I reports and investigation of 7/7/14 at 3:30 indicated the following the procedure on 7/7/14 at 3:30 indicated the following while of thome. The review of the policies and investigation of the procedure of the policies and investigation of the procedure of the policies and investigation of the procedure of the policies and procedure of the procedure of the policies and procedure of the	evelop and implement d procedures that prohibit lect or abuse of the client. review and interview for s of abuse, neglect, ploitation and injuries of reviewed, the facility ent its policy and sure the results of an alleged staff neglect for 8, #4, #5 and #6 were dministrator within 5 the alleged incident. DDS (Bureau of Disabilities Services) stigations were reviewed DPM. The review	W00	00149	The Program Director will be retrained on Indiana MENTOR policy and procedure for completing an investigation. The retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation. The Program Director will be retrained on BDDS reports requirements. The ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist wassist this PD with the next the investigations. Ongoing, all investigations will be reviewed the Area Director and the Qualest Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made at that all recommendations are made at that all recommendations are completed and followed up on a timely manner. Responsible Party: Program Director, Area Director, and Quality Assurance Manager.	nis of ore s vill ee by lity e	08/09/2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

If continuation sheet Page 4 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606		LDING	NSTRUCTION 00	(X3) DATE COMPI 07/10 .	LETED
	PROVIDER OR SUPPLIER		•	3025 GF	DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	clients #1, #2, #3	S on separate reports for 3, #4, #5 and #6 who p home at the time of the					
	of the investigati	/14 indicated the results fon had been reported to nistrator on 3/21/14.					
	on 7/8/14 at 12:3 the facility's abushould be imples	sor) #1 was interviewed 80 PM. AD #1 indicated se and neglect policy mented. AD #1 indicated estigations of allegations					
	exploitation and origin should be	injuries of unknown reported to the thin 5 business days of					
	reviewed on 7/9/ facility's policy of Management dat "Indiana Mentor	icy and procedures were /14 at 5:09 PM. The entitled Quality and Risk red April 2011 indicated, follows the BDDS g policy as outlined in					
	the provider standescribed as followed the BDDS on the prescribed by the abuse, including nonconsensual sometimes molestation; (iii.	dards. An incident ows shall be reported to e incident report form e BDDS:(b.) sexual but not limited to: (i) exual activity; (ii.) sexual) sexual coercion; (iv.) on (e.) failure to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet

Page 5 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CC		(X3) DATE SURVEY
AND PLAN	ADD PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED
		15G606	B. WING		07/10/2014
NAME OF P	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S	
REM-IND	DIANA INC			APOLIS, IN 46222	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
W000156	training (1.) I will be submitte review and deverecommendation days of the incide 9-3-2(a) 483.420(d)(4) STAFF TREATMETHE The results of all i reported to the address of the incide statement o	ENT OF CLIENTS nvestigations must be ministrator or designated			
	accordance with S working days of the Based on record 1 of 5 allegation mistreatment, exunknown origin failed to ensure investigation of clients #1, #2, #2 reported to the abusiness days of Findings included The facility's BI Developmental I reports and investigation of the facility of	review and interview for s of abuse, neglect, aploitation and injuries of reviewed, the facility the results of an alleged staff neglect for 3, #4, #5 and #6 were dministrator within 5 of the alleged incident.	W000156	The Program Director will be retrained on Indiana MENTOR policy and procedure for completing an investigation. To retraining will also include the expectation of the completion the recommendations that are results of the completed investigation and the 5 day requirement for all investigation to be completed. The Program Director will be retrained on BDDS reports requirements. The ensure that all investigations a completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist wassist this PD with the next thr investigations. Ongoing, all investigations will be reviewed the Area Director and the Qual Assurance Specialist to ensure	ns ns no control of see e deby lity

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 6 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G606	B. WING		07/10/2014
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	PROVIDER OR SUPPLIE	R		GREENHILLS LN S	
REM-IND	DIANA INC			NAPOLIS, IN 46222	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	-BDDS report d	ated 3/11/14 indicated		that all issues are addressed,t	hat
	client #2 reporte	ed an allegation of staff		the investigation is completed	
	sleeping while o	on duty in the group		thoroughly, that recommendations are made a	nd
		ew indicated the facility		that all recommendations are	iiu
		allegation of staff		completed and followed up on	in
	-	S on separate reports for		a timely manner.	
		3, #4, #5 and #6 who			
	_	up home at the time of the			
	alleged incident				
	-SIIR dated 3/2	1/14 indicated the results			
	of the investigat	tion had been reported to			
	_	inistrator on 3/21/14.			
	AD (Area Direc	etor) #1 was interviewed			
	on 7/8/14 at 12:	30 PM. AD #1 indicated			
		vestigations of allegations			
	of abuse, neglec				
		l injuries of unknown			
	origin should be	-			
		ithin 5 business days of			
	the alleged incid	lent.			
	9-3-2(a)				
	- (~)				
W000159	483.430(a)				
	` '	ITAL RETARDATION			
	PROFESSIONAL				
		ve treatment program must			
	•	ordinated and monitored by			
	-	l retardation professional.	W000150	Please see W126 The Progra	m 00/00/2014
		vation, record review and	W000159	Director will be retrained on	m 08/09/2014
		of 3 sampled clients (#1,		writing client goals and objecti	ves
	#2 and #3), the	QIDP (Qualified		based on their individual need	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 7 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A DULLI DING 00		COMPLETED	
		15G606	A. BUIL			07/10/	
		10000	B. WINC	_		017107	2011
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					REENHILLS LN S		
REM-IND	DIANA INC			INDIANAPOLIS, IN 46222			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Intellectual Disa	bilities Professional)			The Program Director, in		
	failed to integrat	e, coordinate and			conjunction with the		
	monitor clients #	#1, #2 and #3's active			Interdisciplinary teams, will cre		
		ms. The QIDP failed to			a money goal for clients 1 and		
		•			Ongoing, the Program Director will work with the interdiscipling		
		and #3 were taught to			teams to ensure that each clie	-	
	manage their fin	-			has training goal to identify the		
	assess/reassess c	lient #1's vocational			specific areas of need. Ongoin		
	needs, to develo	p a program of training			all Individualized Support Plar		
	· ·	ients #1 and #2, to ensure			will be reviewed by the Area		
	1 3	3's active treatment			Director and/or Quality Assura	ance	
					Manager, to ensure accuracy	and	
	programs were i	-			to ensure that all areas of nee		
	1	assist the clients to			are met for each client. Pleas		
	achieve their tra	ining objectives and to			see W225 Client # 1 will have		
	ensure clients #1	, #2 and #3 had			vocational needs assessed. T		
		on of medication training			IDT will convene to determine		
	objectives.	on or moureum numming			Noble Tibbs continues to be the		
	objectives.				appropriate placement for him	1.	
					The Program Director and/or Home Manager will set up visit	ite	
	Findings include	: :			for client#1 to attend other day		
					programs that might better fit	•	
	1. The QIDP fai	led to ensure clients #1			needs, with the approval of the		
	and #3 were taus	ght to manage their			IDT. Once the visits are		
		Please see W126.			completed, client #1 will have	а	
	inimited analis.	110000 500 11 120.			choice as to which day progra	ım	
	A The OIDE C.	1. 14 /			he would like to attend. The		
		led to assess/reassess			Home Manager and Program		
	client #1's vocat	ional needs. Please see			Director will be retrained on		
	W225.				completing vocation assessment	ents	
					on each client no less than		
	3. The OIDP fai	led to develop a program			annually, but more as needed		
		etives for clients #1 and			For the next 4 weeks, the Hon Manager will complete no less		
					than 2 observations on each	•	
	#2. Please see W	1221.			client while at the day program	n to	
					determine if any other clients		
	4. The QIDP fai	led to ensure clients #1			require further vocational		
	and #3's active to	reatment programs were			assessments. These		
		ntinuously to assist the			observations will each be		

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G606	B. WING		07/10/2014
NAME OF I	DROWINED OF GUIDNI 122		STREET .	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		3025 G	REENHILLS LN S	
	DIANA INC		INDIAN	IAPOLIS, IN 46222	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	clients to achieve	· ·		reviewed by the Program Dire for further follow up. Ongoing,	l l
	objectives. Pleas	e see W249.		Home Manager will complete	l l
				less than 1 day program	
	5. The QIDP fail	led to ensure clients #1,		observation on each client per	
	#2 and #3 had se	elf-administration of		month, per Indiana MENTOR's	l l
	medication train	ing objectives. Please see		policy and procedures. Ongoir	ng,
	W371.	- -		the Program Director will complete 2 day program	
				observations per quarter on a	nv
	9-3-3(a)			individual client, per Indiana	9
	()			MENTOR's policy and	
				procedures. Please see W22	7
				The Program Director will be	
				retrained on writing client goal and objectives based on their	
				individual needs. The Program	
				Director will be retrained on	'
				including the client goals in the	e
				Individualized Support Plan. T	
				Program Director, in conjunction	on
				with the Interdisciplinary	
				teams, will create a goal surrounding a household chor	_
				for clients 1 and 2. The Progra	
				Director, in conjunction with th	
				Interdisciplinary teams, will cre	ate
				a mealtime goal for client 2.	
				Ongoing, the Program Directo	l l
				will work with the interdisciplin teams to ensure that each clie	-
				has training goal to identify the	
				specific areas of need. Ongoir	
				all Individualized Support Plan	ıs
				will be reviewed by the Area	
				Director and/or Quality Assura	l l
				Manager, to ensure accuracy to ensure that all areas of nee	
				are met for each client. Pleas	
				see W249 The Direct Support	
				Professionals will be retrained	on
				completing formal and informa	al
	l				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 9 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	OO	(X3) DATE SURVEY COMPLETED
		15G606	A. BUILDING B. WING		07/10/2014
NAME OF T	DOMBER OF CURRY WE			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	(3025 G	REENHILLS LN S	
REM-IND	IANA INC		INDIAN	IAPOLIS, IN 46222	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	training goals for each clien	DATE t The
				Direct Support Professional	
				be retrained on documenting	
				formal training goals for each	
				client. After the retraining of	
				the Home Manager will com two (2)weekly observations	-
				ensure that the goals are be	
				completed with each client a	as
				specified for four (4) weeks.	
				These will then be reviewed the Program Director ensuri	-
				that there are no further trai	•
				needs to be addressed. After	<u> </u>
				initial four (4) weeks, the Ho	
				Manager and/or Program D	
				will complete weekly medical administration observations	
				ongoing,and will ensure that	
				needed retrainings will be	
				completed. Ongoing each D	
				will work with each client on	
				specific Individualized Supp Plan that states each goal.	
				the first four weeks, the Hor	
				Manager will complete	
				documentation reviews no le	
				than every 48 hours to ensure that goals are being documents.	
				correctly by each staff. After	
				initial four weeks and ongoing	
				the Home Manager will com	•
				documentation reviews no le	
				than weekly to ensure that a goals are being ran and	dii
				documented appropriately.	Any
				ongoing completion and	
				documentation errors will be	
				brought to the Program Dire	
				action on staff. Please see	
				The Program Director, in	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facilit

Facility ID: 001175

If continuation sheet

Page 10 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 07/10/2014
REM-IND	ROVIDER OR SUPPLIER		3025 G	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W000225	must include, as a Based on observinterview for 1 of the facility failed #1's vocational markets frindings include Observations we #1's sheltered wo 11:39 AM throug AM, client #1 we break area with 1 PM, an audible a and client #1's co	ve functional assessment applicable, vocational skills. ation, record review and f 3 sampled clients (#1), at to assess/reassess client needs.	W000225	conjunction with the Interdisciplinary teams, will cre a goal surrounding medication administration for clients 1, 2, 3. Ongoing, the Program Direct will work with the interdisciplin teams to ensure that each clie has training goal to identify the specific areas of need. Ongoir all Individualized Support Plan will be reviewed by the Area Director and/or Quality Assura Manager, to ensure accuracy to ensure that all areas of nee are met for each client. Responsible Party: Program Director, Area Director, and Quality Assurance Manager. Client # 1 will have his vocation needs assessed. The IDT willconvene to determine if Not Tibbs continues to be the appropriate placementfor him. The Program Director and/or Home Manager will set up visifor client#1 to attend other day programs that might better fit I needs, with theapproval of the IDT. Once the visits are completed, client #1 will have choice as to whichday program he would like to attend. The Home Manager and Program Director will be retrained on completingvocation assessme on each client no less than annually, but more as needed	and ctor ary ent eir ng, as ance and d onal 08/09/2014 oble ots / his e a m

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 11 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE		
		15G606	B. WIN	IG		07/10/2	2014	
NAME OF E	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	ROVIDER OR SUFFLIER			3025 GREENHILLS LN S				
	DIANA INC			INDIAN	APOLIS, IN 46222			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		_	DATE	
		k station with his			For the next 4 weeks, the Hom Manager will complete no less			
		ent #1 entered the			than 2observations on each cli			
	_	alked from the outdoor			while at the day program to			
		inside cafeteria/vending			determine if any otherclients			
	area. Client #1 re	emained in the inside			require further vocational			
	cafeteria/vending	g area pacing between			assessments. These observations will each			
	tables until 12:1:	5 PM. At 12:15 PM,			bereviewed by the Program			
	client #1 returne	d to the outside break			Director for further follow up.			
	area and paced b	etween the outdoor			Ongoing, the Home Manager v	vill		
	tables before reti	urning back inside the to			complete no less than 1 day			
	the inside cafeter	ria/vending area. Client			programobservation on each client per month, per Indiana			
		throughout the duration			MENTOR's policy			
	of the observation	· ·			andprocedures. Ongoing, the			
		period.			Program Director will complete	2		
	Day Services Me	anager (DSM) #1 was			day program observationsper			
	~	7/10/14 at 12:40 PM.			quarter on any individual client	.,		
		"[Client #1] enjoys being			per Indiana MENTOR's policy andprocedures. Responsible			
		the social aspects of			Party: Home Manager and			
		•			Program Director			
		day. [Client #1] doesn't						
		ork here though. I've						
	_	line in [client #1's] skills,						
	_	as he used to be a few						
	٠	t know if it's because he's						
	getting older and							
	~	we can't get him to work.						
	1	e will do is sweeping the						
	floors and he trie	es to help the vending						
	machine guy wh	en they come in to refill						
	the vending mac	hines. Out of a six hour						
	work day we use	ed to be able to get [client						
	#1] to work abou	it three to four hours of						
	the day. The last	year and half or so, he						
	_	ork for fifteen or twenty						
	_	ay. [Client #1] really						
		J []						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 12 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/10/2014			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	to socialize more peers. It may be something like as program. Someth to be social and h	ne social aspect and tends with staff than his time to think about n adult day care type of ning that will allow him have some good activity He just isn't motivated to more."					
	Client #1's record was reviewed on 7/8/14 at 11:24 AM. Client #1's ISP (Individual Support Plan) dated 5/15/14 indicated, "[Client #1] attends [sheltered workshop]. He participates in the sheltered work environment. He does participate in work when it is available."						
	Professional) #1 7/10/14 at 1:45 P client #1 should determined if the	sheltered workshop is ocational setting for					
	9-3-4(a)						
W000227	specific objectives client's needs, as i comprehensive as paragraph (c)(3) o	gram plan states the necessary to meet the dentified by the sessment required by f this section.					
	Based on record	review and interview for	W000227	The Program Director will be	08/09/2014		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet

Page 13 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED	
		15G606	B. WIN			07/10/2014	
					ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF I	PROVIDER OR SUPPLIEF	8		1	REENHILLS LN S		
REM-IN	DIANA INC				APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	1
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	2 of 3 sampled clients (#1 and #2), the facility failed to develop a program of				retrained on writing client goal and objectives based on their	S	
					individual needs. The Program		
	training objectiv	es for clients #1 and #2.			Director will be retrained on	'	
					including the client goals in the	;	
	Findings include	: :			Individualized Support Plan. T		
					Program Director, in conjunction	on	
	1. Client #1's red	cord was reviewed on			with the Interdisciplinary teams,will create a goal		
	7/8/14 at 11:24	AM. Client #1's ISP			surrounding a household chor	e	
	(Individual Supr	oort Plan) dated 5/15/14			for clients 1 and 2. The Progra		
	`	T (Interdisciplinary			Director, in conjunction with th	e	
	Team) should prioritize formal goals and				Interdisciplinary teams, will cre	ate	
		goals into the ISP. Client			a mealtime goal for client 2. Ongoing, the Program Directo		
		/15/14 indicated the IDT			will work with the interdisciplin		
					teams to ensure that each clie	· I	
		[Client #1] will gain			has training goal to identify the		
	•	completing a household			specific areas of need. Ongoir		
		ormal training." Client			all Individualized Support Plan	s	
	#1's record did n				will be reviewed by the Area Director and/or Quality Assura	nee	
		of a formal training			Manager, to ensure accuracy		
	objective regard	ing household chores.			to ensure that all areas of nee		
					are met for each client.		
	2. Client #2's red	cord was reviewed on			Responsible Party: Program		
	7/8/14 at 10:56	AM. Client #2's ISP			Director, Area Director, and		
	dated 2/16/14 in	dicated the IDT should			Quality Assurance Manager.		
	prioritize formal	goals and incorporate					
	the goals into the	e ISP. Client #2's ISP					
	dated 2/16/14 in						
		Client #2] will gain					
		completing a household					
	*	ormal training. [Client #2]					
	_	ependence with meal					
		rough a formal training					
	goal." Client #2's record did not indicate documentation of formal training						
		•					
objectives regarding household chores or							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G606	B. WING		07/10/2014	
	PROVIDER OR SUPPLIE	R	3025 G	ADDRESS, CITY, STATE, ZIP CODE GREENHILLS LN S NAPOLIS, IN 46222		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
W000249	Professional) #1 7/8/14 at 1:30 P formal training of developed based recommendation 9-3-4(a) 483.440(d)(1) PROGRAM IMPL As soon as the informulated a clier each client must be treatment program interventions and number and frequencies achievement of the individual professed on record 2 of 3 sampled of facility failed to #3's active treatment implemented conclients to achieve objectives. Findings include 1. Client #1's reference 7/8/14 at 11:24 (Qualified Intelligence)	d Intellectual Disabilities was interviewed on M. QIDP #1 indicated objectives should be d on IDT/ISP ns. EMENTATION terdisciplinary team has nt's individual program plan, receive a continuous active m consisting of needed services in sufficient tency to support the ne objectives identified in gram plan. I review and interview for clients (#1 and #3), the ensure clients #1 and ment programs were outinuously to assist the re their training	W000249	The Direct Support Profession will be retrained on completing formaland informal training go for each client. The Direct Support Profession will be retrained on documenti formaltraining goals for each client. After the retraining occurs, the Home Manager will complete (2)weekly observations to ens that the goals are being completed with eachclient as specified for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs to beaddressed.	als als tals two ure	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 15 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		15G606	B. WIN			07/10/	2014
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	2			REENHILLS LN S		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	indicated the following a limit of the second and secon	lowing: cated, "Review of civil improve his physical cairing assistance to k independently. Four conday, Wednesday, ay), [client #1] will minutes of physical P or less in 70% of trials Consecutive Months). performance: 9%. Ins regarding instructional are advised to continue itent #1] to improve his physical fitness levels betable and improvement tation of the goals is will improve his from requiring staff inpeting a task Two times a week unday), [client #1] will dishes for dinner with in 70% of trials for evel of performance: 1%. Ins regarding instructional (Home Manager) and int fully (sic) goals and ick to the PD (Program in weekly basis;		TAG	After the initial four (4) weeks, Home Manager and/or ProgramDirector will complete weekly medication administrat observations ongoing, and will ensure that all needed retraining will be completed. Ongoing each DSP will work weach client on their specificIndividualized Support Plan that states each goal. For the first four weeks, the Home Manager will complete documentationreviews no less than every 48 hours to ensure that goals are being documentedcorrectly by each staff. After the initial four weeks and ongoing, the Home Manager willcomplete documentation reviews no less than weekly to ensure that all goals arebeing and documented appropriately. Any ongoing completion and documentation errors will be brought to the Program Director attention for further corrective action on staff. Responsible Party: Home Manager and Program Director of the program Direc	ion ngs vith ran v.	DATE
	1		1		l e e e e e e e e e e e e e e e e e e e		

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606		LDING	NSTRUCTION 00	(X3) DATE COMPL 07/10/	ETED
	PROVIDER OR SUPPLIER		•	3025 GF	DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	adequately by sta	aff. This results in lower the client."					
	goals/objectives: (1.) [Client #1] v skills from relyir independent. Da his teeth with 2 v trials for TCM. O Performance: 0% regarding instruct Improvement is: HM and staff are implementation; (2.) [Client #1] v fitness from requ completing a tas times a week (M Friday and Sund participate in 30 fitness with 1 VI for TCM. Currer 0%. Recommend instructional teel to continue to we improve his perc fitness levels (sid improvement in the goals is requi (3.) [Client #1] v skills from requi completing a tas	will improve his hygiene ag on staff to becoming ity [client #1] will brush VPs or less in 80% of Current Level of A Recommendations ctional technique: necessary for this goal. responsible for goal will improve his physical airing assistance to k independently. Four onday, Wednesday, ay), [client #1] will minutes of physical P or less in 70% of trials at level of performance: dations regarding anique: Staff are advised ork with [client #1] to entages for physical e) are unacceptable and the implementation of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet

Page 17 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G606	B. WIN	G		07/10/	/2014
NAME OF F	PROVIDER OR SUPPLIEF	}			DDRESS, CITY, STATE, ZIP CODE		
DEMINI	NANIA INIO				REENHILLS LN S		
REM-INL	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		prepare two side dishes					
	for dinner with two VPs or less in 70% of trials for TCM. Current level of						
	1 ^	6. Recommendations					
	"	ctional technique: HM					
		ement fully (sic) goals					
		rt back to the PD on a bi					
	weekly basis;						
	Comments: Goa	•					
adequately by staff. This results in lower							
	performance by	the client."					
	2. Client #3's red	cord was reviewed on					
		AM. Client #3's QIDP					
		ary forms indicated the					
	following:	, 1011110 1114104104 4110					
	<i>S</i> .						
	-April 2014 indi	cated, "Review of					
	goals/objectives	:					
	(1.) [Client #3] v	will take a shower with					
	two VPs in 100%	% of trials for TCM.					
	Current level of	performance: 0% no data					
	provided. Recon	nmendations regarding					
	instructional tecl	hnique: Goals should be					
	ran (sic) daily fo	or the clients. No trials is					
	(sic) unacceptab	le;					
	(2.) [Client #3] v	will increase his domestic					
		ng on staff to completing					
	1	ll independently. [Client					
		e his cooking skills. Two					
	times a week, [c	_					
	/ <u>-</u>	ednesdays prepare a side					
	I -	Ps or less in 80% of trials					
		nt level of performance:					
	l		ı				1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11

Facility ID: 001175

If continuation sheet

Page 18 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606	(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE : COMPL 07/10 /	ETED
	PROVIDER OR SUPPLIEF		30)25 GR	DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IE PRE T <i>A</i>	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	instructional technan daily for the unacceptable; (3.) [Client #3] was management ski to becoming mo management. [Ca week (Tuesday will count out \$1 with three VPs of TCM. Current le Recommendation technique: Goals for the clients. No unacceptable; (4.) [Client #3] was communication communication communication repeat numbers of VPs or less in 80 Current level of Recommendation technique: Goals for the clients. No unacceptable; (5.) [Client #3] was fitness from requesting tasks times a week (Sommendation technique: Goals for the clients. No unacceptable; (5.) [Client #3] was fitness from requesting tasks times a week (Sommendation technique: Goals for the clients. No unacceptable; (5.) [Client #3] was fitness from requesting tasks times a week (Sommendation technique: Goals for the clients. No unacceptable; (5.) [Client #3] was fitness from requesting tasks times a week (Sommendation technique: Goals for the clients. No unacceptable; (5.) [Client #3] was fitness from requesting tasks times a week (Sommendation technique: Goals for the clients. No unacceptable; (5.) [Client #3] was fitness from requesting tasks times a week (Sommendation technique: Goals for the clients. No unacceptable; (5.) [Client #3] was fitness from requesting tasks times a week (Sommendation technique: Goals for the clients. No unacceptable;	will increase his from having limited skills to have more skills. [Client #3] will one through ten with two 0% of trials for TCM. performance: 0%. ns regarding instructional s should be ran (sic) daily to trials is (sic) will improve his physical airing staff assistance to s independently. Four					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 19 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606		(X2) MULTIPLE A. BUILDING B. WING	00	COMP	E SURVEY PLETED D/2014	
	PROVIDER OR SUPPLIER		STREE 3025	ET ADDRESS, CITY, STATE, ZIP COI GREENHILLS LN S ANAPOLIS, IN 46222	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	regarding instruct and staff are acc implementation; Comments: No g #3]. This is unaccorrected for the -May 2014 indic goals/objectives: (1.) [Client #3] v two VPs in 100% Current level of provided. Recon instructional technic ran (sic) daily fo (sic) unacceptab (2.) [Client #3] v skills from relying the domestic ski #3] will improve times a week, [c Mondays and W dish with two VI for TCM. Curren 1%. Recommend instructional technic ran (sic) daily fo (sic) unacceptab (3.) [Client #3] v management ski to becoming mo	consider the commendations betional technique: HM countable for goal goals were run for [client receptable and will be following month." atted, "Review of sevil take a shower with conference: 0% no data amendations regarding anique: Goals should be rethe clients. No trials is lee; will increase his domestic and on staff to completing all independently. [Client explain the chients has cooking skills. Two lient #3] will on ednesdays prepare a side Ps or less in 80% of trials at level of performance: dations regarding anique: Goals should be rethe clients. No trials is				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 20 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G606		(X2) MULTIPLE A. BUILDING B. WING	00	COMP	ESURVEY LETED 0/2014	
	F PROVIDER OR SUPPLIER	2	STREE 3025	ET ADDRESS, CITY, STATE, ZIP CO GREENHILLS LN S ANAPOLIS, IN 46222	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	will count out \$3 with three VPs of TCM. Current le Recommendation technique: Goals for the clients. No unacceptable; (4.) [Client #3] which communication communication communication repeat numbers of VPs or less in 80 Current level of Recommendation technique: Goals for the clients. No unacceptable; (5.) [Client #3] which fitness from requestions a week (Some Wednesday and participate in this fitness with one trials for TCM. One performance: 0% regarding instructions and staff are accessing the performance: 0% regarding instructions and staff are accessing the performance: 0% regarding instructions with one trials for TCM. One performance: 0% regarding instructions with one trials for TCM. One performance: 0% regarding instructions with one trials for TCM. One performance: 0% regarding instructions with one trials for TCM. One performance: 0% regarding instructions with one trials for TCM. One performance: 0% regarding instructions with one trials for TCM. One performance: 0% regarding instructions with the performance: 0% regarding instructions. The performance with the performance	will increase his from having limited skills to have more skills. [Client #3] will one through ten with two 0% of trials for TCM. performance: 0%. ns regarding instructional s should be ran (sic) daily to trials is (sic) will improve his physical uiring staff assistance to s independently. Four unday, Monday, Friday) [client #3] will rty minutes of physical VP or less in 70% of Current level of %. Recommendations ctional technique: HM ountable for goal				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 21 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G606			LDING	NSTRUCTION 00	(X3) DATE COMPL 07/10 /	ETED	
	F PROVIDER OR SUPPLIER	·	•	3025 GF	DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S	•	
REM-I	NDIANA INC			INDIANA	APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	goals/objectives (1.) [Client #3] whill show the domestic skin #3] will improve times a week, [commondays and Wordsh with two Vordsh for TCM. Current 1%. Recommendation to be coming more management. [Commondays and Wordsh with the Vordsh for TCM. Current 1%. Recommendation to be coming more management. [Commondays and Wordsh for the Client #3] which will count out \$100 more with three VPs of TCM. Current less that the clients is the commondation to the clients. Note that the clients is the communication communication communication repeat numbers of VPs or less in 80 more with the clients in \$100 more peat numbers of the clients in \$100 more pea	will increase his domestic ng on staff to completing all independently. [Client to his cooking skills. Two dient #3] will on sednesdays prepare a side Ps or less in 80% of trials not level of performance: dations regarding hinque: Goals should be or the clients. No trials is de; will increase his money alls from relying on staff are independent in money allent #3] will three times and the complete sin 70% of trials for evel of performance: 0%. In segarding instructional is should be ran (sic) daily to trials is (sic)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 22 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE : COMPL		
ANDILAN	OI CORRECTION	15G606		LDING	00	07/10/	
		100000	B. WIN			07/10/	2017
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REM-IND	IANA INC				REENHILLS LN S APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ns regarding instructional					
	-	s should be ran (sic) daily					
	for the clients. N	o trials is (sic)					
	unacceptable;						
		vill improve his physical					
	•	niring staff assistance to					
	1 0	independently. Four					
	times a week (Su						
	_	Friday) [client #3] will					
		rty minutes of physical					
		VP or less in 70% of					
	trials for TCM. (Current level of					
	•	6. Recommendations					
	regarding instruc	etional technique: HM					
	and staff are acco	ountable for goal					
	implementation;						
	Comments: Very	few goals were run for					
	[client #3]."						
	QIDP (Qualified	Intellectual Disabilities					
	Professional) #1	was interviewed on					
	7/8/14 at 1:30 PM	M. QIDP #1 indicated					
	clients #1 and #3	s's active treatment					
	program should	be implemented by					
	facility staff at ea	ach available					
	opportunity. QII	OP #1 indicated facility					
		n offering the clients					
	training opportu	_					
	- 11						
	9-3-4(a)						
	`						
W000368	483.460(k)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet

Page 23 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLETED	
		15G606	B. WIN			07/10/201	4
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t			REENHILLS LN S		
REM-INC	DIANA INC				APOLIS, IN 46222		
					74 OLIO, 114 40222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	MPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY		DATE
	DRUG ADMINIST						
		ug administration must gs are administered in					
		ne physician's orders.					
	Based on record review and interview for		l wo	00368	The Direct Support Profession	als 08	/09/2014
		lients (#2) plus 2	'''	00000	will be retrained on		, 0 , 7 = 0 1 .
	_	s (#4 and #6), the facility			medicationadministration. This		
		* * * * * * * * * * * * * * * * * * * *			training will include the times t	nat	
		medications were			medicationadministration is		
		ordered by the physician			completed, which must be according to the Med Sheets.		
	for clients #2, #4	l and #6.			After the retraining occurs, the		
	Findings include:				Home Manager, Program		
					Director, and/orProgram Nurse	ctor, and/orProgram Nurse	
					will complete two (2) weekly		
	The facility's BD	DDS (Bureau of			medication		
	_	Disabilities Services)			administrationobservations to		
	•	stigations were reviewed			ensure that the administration being completed according	is	
	•) PM. The review			toIndiana MENTOR policy and		
	indicated the following				procedures for four (4) weeks.		
	mulcated the for	lowing.			These will then bereviewed by	the	
	DDDC rapart de	ated 2/16/14 indicated			Program Director ensuring tha	t	
	•				there are no further		
		receive Oxybutynin 5			trainingneeds. After the initial four (4) weeks,	the	
	,	Cogentin 0.5 milligram			Home Manager, Program		
		rdal 0.5 milligram tablet			Director,and/or Program Nurse		
	on 2/14/14.				will complete weekly medication		
					administrationobservations		
	-BDDS report da	ated 2/20/14 indicated			ongoing, and will ensure that a		
	client #2 did not	receive her clonazepam			needed future retrainings willb	e	
	tablet at 7:00 AN	•			completed. Ongoing each DSP will completed.	ate	
					Medication Administration as		
	-RDDS report de	ated 3/1/14 indicated			expected byIndiana MENTOR	s	
	*	receive his Lantus 10			policy and procedures.		
		receive his Lantus 10			Responsible Party: Home		
	units on 3/1/14.				Manager, Program Director, a	nd	
					Program Nurse		
	•	ated 6/3/14 indicated					
	client #4 did not	receive a routine dose of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 24 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		15G606	B. WIN	G		07/10/	2014
NAME OF F	ROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					REENHILLS LN S		
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION	N OF CORRECTION	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	DEFICIENCY)	DATE	
	Paroxetine on 5/	14/14.					
	_	ated 6/3/14 indicated					
		t received her prescribed					
	_	on 5/27/14, 5/28/14 and					
	5/29/14. The 6/3	/14 BDDS report					
	· ·	staff indicated he forgot					
	to punch the med	dication out and					
	administer it to t	he client."					
	1. Client #2's red	cord was reviewed on					
	7/8/14 at 10:56 A	AM. Client #2's POF					
	dated 7/1/14 ind	icated client #2 had a					
	physicians order	for Levothyroxine 112					
		one tablet by mouth					
		ypothyroidism at 6:30					
		POF dated 7/1/14					
		#2 had a physicians order					
		0.5 milligrams tablet					
	•	ne tablet by mouth twice					
	a day at 7:00 AN	<u>-</u>					
	a day at 7.00 m	1 und 3.00 1 W.					
	2 Client #Δ's red	cord was reviewed on					
		M. Client #4's POF dated					
	6/24/14 indicate						
		for Paroxetine 20					
		every night at bedtime					
	_						
	6/24/14 indicated	nt #4's POF dated					
		for Lantus Solostar Pen,					
	_	aily before breakfast for					
	diabetes.						
	2 01:	1					
	3. Client #6's rec	cord was reviewed on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YEOQ11 Facility ID: 001175

If continuation sheet Page 25 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606			A. BUILDING	OD	(X3) DATE : COMPL 07/10/	ETED	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION DATE	
W000371	6/24/14 indicated physicians order milligram tablet, twice a day for in milligram tablet, mouth twice dail and Risperdal 1 in one tablet by mo LPN (Licensed Finterviewed on 7 #1 indicated mediadministered as physician. 9-3-6(a) 483.460(k)(4) DRUG ADMINIST The system for drussure that clients their own medicatiteam determines to medications is an if the physician do Based on observatinterview for 3 of #2 and #3), the facilients #1, #2 and #3	for Oxybutynin 5 one tablet by mouth neontinence, Cogentin 1 take one tablet by y (Parkinson symptoms) milligram tablet, take uth twice daily (bipolar). Practical Nurse) #1 was /8/14 at 1:25 PM. LPN lication should be prescribed by the RATION ag administration must are taught to administer ons if the interdisciplinary that self-administration of appropriate objective, and es not specify otherwise. ation, record review and f 3 sampled clients (#1, acility failed to ensure d #3 had on of medication training	W00037	The Program Director will be retrained on writing client go and objectives based on the individual needs. The Progound Director will be retrained or including the client goals in Individualized Support Plar Program Director, in conjur with the Interdisciplinary teams, will create a goal surrounding medication	oals eir ram n the n. The	08/09/2014	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet

Page 26 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606		LDING	ONSTRUCTION 00	(X3) DATE COMPL 07/10 /	ETED
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	group home on 7 through 8:00 AM (Direct Support I the group home's administration. A entered the mediarea and prepare medications by r from the pharma and placed the mediarea placed the mediarea and prepare medications by r from the pharma and placed the mediarea and pre-filled content of the administration of the administration of the pharma and a pre-filled content administration of the pharma and placed the administration of the pharma and placed the mediare the administration of the pharma and placed the mediare the pharma and placed the administration of the pharma administration to the pharma administration the pharma and placed the pharma administration the pharma and placed the pharma and pl	rviewed on 7/8/14 at 1 indicated clients #1, #2			administration for clients 1, 2, 3. Ongoing, the Program Dire will work with the interdisciplin teams to ensure that each clie has training goal to identify the specific areas of need. Ongoin all Individualized Support Plar will be reviewed by the Area Director and/or Quality Assura Manager, to ensure accuracy to ensure that all areas of need are met for each client. Responsible Party: Program Director, Area Director, and Quality Assurance Manager.	ctor lary ent eir ng, ns ance and	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet

Page 27 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED	
15G606				LDING		07/10/	
		130000	B. WIN			077107	2014
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S		
REM-INDIANA INC					APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		AM. Client #1's ISP					
	`	ort Plan) dated 5/15/14					
		nt #1] is reliant on others					
		lth and safety needs are					
		is unable to administer					
		prescribed and must rely					
		rs for appropriate					
		Client #1's ISP dated					
		d the recommendation to					
		ation administration					
	I -	Formal goal." Client #1's					
		dicate documentation of					
		tion training objective or					
		tion training support to					
	teach client #1 to	administer his own					
	medications.						
	2. Client #2's rec	ord was reviewed on					
	7/8/14 at 10:56 A	AM. Client #2's ISP					
	dated 2/16/14 inc	dicated, "[Client #2] is					
	reliant on others	to ensure her health and					
	safety needs are	met. [Client #2] is					
	unable to admini	ster medications as					
	prescribed and m	nust rely on staff and					
	others for approp	oriate administration."					
	Client #2's ISP d	ated 2/16/14 indicated					
	the recommenda	tion to "Increase					
	medication admi	nistration skills through					
	a formal goal." C	Client #2's record did not					
	indicate docume	ntation of a formal					
	medication train	ing objective or informal					
		ing support to teach					
	client #2 to admi	nister her own					
	medications.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet

Page 28 of 32

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G606	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/10/2014		
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	3. Client #3's record was reviewed on 7/8/14 at 10:07 AM. Client #3's ISP dated 1/24/14 indicated, "[Client #3] cannot self medicate." Client #3's ISP dated 1/24/14 indicated the recommendation to "Increase medication administration skills through a formal goal." Client #3's record did not indicate documentation of a formal medication training objective or informal medication training support to teach client #3 to administer his own medications. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/8/14 at 1:30 PM. QIDP #1 indicated clients #1, #2 and #3 did not have medication administration training objectives. 9-3-6(a)					
W000440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 3 additional clients (#4, #5 and #6), the facility failed to conduct evacuation drills for each quarter on each shift of staff.	W000440	All Direct Support Professiona will receive a retraining every other month to ensure that the understand the importance of completing the monthly fire dri The retraining will include reviewing a copy of the Fire DrillSchedule. Ongoing, the Di	y Ils.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet

Page 29 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X.	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED	
15G606 B. WING	07/10/2014	
STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER 3025 GREENHILLS LN S		
REM-INDIANA INC INDIANAPOLIS, IN 46222		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE	
Findings include: The facility's evacuation drill record was reviewed on 7/8/14 at 1:07 PM. The review indicated the facility failed to conduct an evacuation drill for 6 of 6 clients (#1, #2, #3, #4, #5 and #6) for the first quarter, January, February and March 2014 for the day shift, for the fourth quarter and October, November and December 2013 for the day and evening shifts/hours. Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that thehealth and safety of the client's needs are met. Ongoing all completed fire drill reports will be turned in to andreviewed by Quality Assurance for accuracy and thoroughness of each drill. Responsible Party: Home Manager	to g, II	
an evacuation drill should be conducted		
for each shift once per quarter.		
9-3-7(a)		
W009999		
STATE FINDINGS: W009999 All staff are given reminders as to when their annual training requirements are due to expire	to 08/09/2014	
The following Community Residential requirements are due to expire. Those that fail to keep them up to	to	
Facilities for Persons with date receive suspension until		
Developmental Disabilities Rule was not completed. Ongoing, the HR		
met Representative, with the help of		
the Program Director and Area (1) 460 IAC 9-3-3 Facility Staffing the Program Director, will keep the Home Manager and Direct Care staff up	qu	
(e) Prior to assuming residential job to date with the staff annual	'	
duties and annually thereafter each training expiration dates,		
residential staff person shall submit including but not limited to annua	al	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet Page 30 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CO	DRRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G606	A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 07/10 /	ETED
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				3025 GI	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
	(EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
wr PP x-r Ma of rea ski mi sha lab con trea dia pre TH AS Ba 1 o Suj fai scr Fir DS on ind scr	itten evidence D) tuberculosi ay was completed, and by who in test result is illimeters or morall be done with coratory examinate a diagnosis for the escribed by the SEVIDENCEI SEVIDENCEI Sed on record to f 3 sampled stapport Professical de to complete reening checklished include: SP #1's personner 7/8/14 at 12:10 dicated DSP #1 reening complete include annual screening checklished in the complete include includes include:	that a Mantoux (5TU, so skin (TB) test or chest eted. The result of the recorded in millimeter in the date given, date im administered. If the significant (ten (10) ore), then a chest film in other physical and nations as necessary to osis. Prophylactic exprovided as per length of time physician. JLE WAS NOT MET DBY: The review and interview for aff (DSP (Direct onal) #1), the facility expressed and annual PPD st for employed staff.			Mantoux tests, or xrays. DSP will have an annual Mantoux to (or chest x-ray) completed. Responsible Party: Home Manager, Administrative Assistant, Program Director, a Area Director.	est	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11 Facility ID: 001175

If continuation sheet

Page 31 of 32

PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2014				
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O AD (Area Direc on 7/8/14 at 12: DSP #1 should completed. AD	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) Etor) #1 was interviewed 15 PM. AD #1 indicated have an annual screening #1 indicated she would	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	follow up with the HR (Human Resources) department to confirm if additional documentation was available. AD #1 submitted an electronic mail message on 7/8/14 at 6:26 PM which indicated, "[DSP #1] must be outdated on his chest x-ray. We were unable to come up with anything, even from the doctor, showing otherwise." 9-3-3(e)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YE0Q11

Facility ID: 001175

If continuation sheet

Page 32 of 32